A BILL FOR AN ACT

CONCERNING A HOSPITAL PROVIDER FEE, AND, IN CONNECTION THEREWITH, AUTHORIZING THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING TO CHARGE AND COLLECT A HOSPITAL PROVIDER FEE AND SPECIFYING THE ALLOWABLE USES OF THE FEES.

Bill Summary

(Note: This summary applies to this bill as introduced and does not necessarily reflect any amendments that may be subsequently adopted.)

Authorizes the department of health care policy and financing (department) to charge and collect from licensed or certified hospitals a hospital provider fee (fee). Authorizes the medical services board to
establish the amount of the fee that shall not exceed the federal limit and
to promulgate rules governing the administration and collection of the
fee. Specifies that the fee shall:

- Supplement and not supplant existing general fund
  appropriations to hospital providers unless payments to
  other medicaid providers are reduced;
- Be used for increasing reimbursements to hospitals under
  medicaid and the Colorado indigent care program,
  expanding eligibility for medicaid and the children's basic
  health plan (CHP+), and paying the costs of the department
  in administering the fee;
- Be returned if the federal government does not approve the
  fee; and
- Cease if the federal government no longer provides
  matching federal funds for the fee.

Establishes the hospital provider fee oversight and advisory board
(board) to make recommendations to the department concerning the
amount of the fee, procedures for collecting the fee, and changes to the
eligibility requirements for assistance if moneys from the fee are
insufficient to pay for all of the proposed eligibility expansions. Specifies
membership of the board. Directs the board to report annually to
specified committees of the general assembly, the governor, and the
medical services board.

Establishes an additional hospital reimbursement based upon a
hospital's performance in providing improved health outcomes for
recipients.

Subject to sufficient moneys being received from the fee and the
matching federal funds:

- Expands eligibility for medicaid to:
  - Parents of children eligible for medical assistance or
    CHP+ to up to 100% of the federal poverty level;
  - Disabled individuals participating in a medicaid
    buy-in program to up to 400% of the federal poverty
    level; and
  - Childless adults or adults without a dependent child
    in the home to up to 100% of the federal poverty
    level subject to federal authorization.
- Provides for continuous eligibility in medicaid for children
  for 12 months.
- Expands eligibility for children and pregnant women under
  CHP+ to up to 250% of the federal poverty level.

Directs that if moneys are insufficient to fully fund the proposed
eligibility expansions, the state board, subject to the approval of the joint
budget committee, by rule may reduce the medical benefits offered or
reduce the eligibility levels, but the state board may not reduce the
eligibility levels below the current levels. Provides that any rule reducing medical benefits or eligibility expires on the following May 15 unless the general assembly acts by bill to extend the rule.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. Part 4 of article 4 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SECTION to read:

25.5-4-402.3. Providers - hospital - provider fees - legislative declaration - federal waiver - fund created - rules - advisory board - repeal. (1) Short title. This section shall be known and may be cited as the "Health Care Affordability Act of 2009".

(2) Legislative declaration. The general assembly hereby finds and declares that:

(a) The state and the providers of publicly funded medical services, and hospital providers in particular, share a common commitment to comprehensive health care reform;

(b) Hospital providers within the state incur significant costs by providing uncompensated emergency department care and other uncompensated medical services to low-income and uninsured populations; and

(c) This section is enacted as part of a comprehensive health care reform and is intended to provide the following state services and benefits:

(I) Providing a payer source for some low-income and uninsured populations who may otherwise be cared for in emergency departments and other settings in which uncompensated care is provided;
(II) REDUCING THE UNDERPAYMENT TO COLORADO HOSPITALS
PARTICIPATING IN PUBLICLY FUNDED HEALTH INSURANCE PROGRAMS;

(III) REDUCING THE NUMBER OF PERSONS IN COLORADO WHO ARE
WITHOUT HEALTH CARE BENEFITS;

(IV) REDUCING THE NEED OF HEALTH CARE PROVIDERS TO SHIFT
THE COST OF PROVIDING UNCOMPENSATED CARE TO OTHER PAYERS; AND

(V) EXPANDING ACCESS TO HIGH-QUALITY, AFFORDABLE HEALTH
CARE FOR LOW-INCOME AND UNINSURED POPULATIONS.

(3) Hospital provider fee. (a) BEGINNING WITH THE FISCAL YEAR
COMMENCING JULY 1, 2009, AND EACH FISCAL YEAR THEREAFTER, THE
STATE DEPARTMENT IS AUTHORIZED TO CHARGE AND COLLECT HOSPITAL
PROVIDER FEES, AS DESCRIBED IN 42 CFR 433.68 (b), ON OUTPATIENT AND
INPATIENT SERVICES PROVIDED BY ALL LICENSED OR CERTIFIED HOSPITALS,
REFERRED TO IN THIS SECTION AS "HOSPITALS", FOR THE PURPOSE OF
OBTAINING FEDERAL FINANCIAL PARTICIPATION UNDER THE STATE
MEDICAL ASSISTANCE PROGRAM AS DESCRIBED IN THIS ARTICLE AND
ARTICLES 5 AND 6 OF THIS TITLE, REFERRED TO IN THIS SECTION AS THE
STATE MEDICAL ASSISTANCE PROGRAM, AND THE COLORADO INDIGENT
CARE PROGRAM DESCRIBED IN PART 1 OF ARTICLE 3 OF THIS TITLE,
REFERRED TO IN THIS SECTION AS THE "COLORADO INDIGENT CARE
PROGRAM". THE HOSPITAL PROVIDER FEES SHALL BE USED TO:

(I) INCREASE REIMBURSEMENT TO HOSPITALS FOR PROVIDING
MEDICAL CARE UNDER:

(A) THE STATE MEDICAL ASSISTANCE PROGRAM; AND

(B) THE COLORADO INDIGENT CARE PROGRAM;

(II) INCREASE THE NUMBER OF PERSONS COVERED BY PUBLIC
MEDICAL ASSISTANCE; AND
(III) PAY THE ADMINISTRATIVE COSTS TO THE STATE DEPARTMENT IN IMPLEMENTING AND ADMINISTERING THIS SECTION.

(b) THE PROVIDER FEES SHALL BE ASSESSED PURSUANT TO RULES ADOPTED BY THE STATE BOARD, PURSUANT TO SECTION 24-4-103, C.R.S. THE AMOUNT OF THE FEE SHALL BE ESTABLISHED BY RULE OF THE STATE BOARD BUT SHALL NOT EXCEED THE FEDERAL LIMIT FOR SUCH FEES. IN ESTABLISHING THE AMOUNT OF THE FEE AND IN PROMULGATING THE RULES GOVERNING THE FEE, THE STATE BOARD SHALL:

(I) CONSIDER RECOMMENDATIONS OF THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO SUBSECTION (6) OF THIS SECTION;

(II) ESTABLISH THE AMOUNT OF THE PROVIDER FEE SO THAT THE AMOUNT COLLECTED FROM THE FEE AND FEDERAL MATCHING FUNDS ASSOCIATED WITH THE FEE ARE SUFFICIENT TO PAY FOR THE ITEMS DESCRIBED IN PARAGRAPH (a) OF THIS SUBSECTION (3), BUT NOTHING IN THIS SUBPARAGRAPH (II) SHALL REQUIRE THE STATE BOARD TO INCREASE THE PROVIDER FEE ABOVE THE AMOUNT RECOMMENDED BY THE ADVISORY BOARD; AND

(III) ESTABLISH THE AMOUNT OF THE PROVIDER FEE SO THAT THE AMOUNT COLLECTED FROM THE FEE IS APPROXIMATELY EQUAL TO OR LESS THAN THE AMOUNT OF THE APPROPRIATION SPECIFIED FOR THE FEE IN THE GENERAL APPROPRIATION ACT OR ANY SUPPLEMENTAL APPROPRIATION ACT.

(c) (I) IN ACCORDANCE WITH THE REDISTRIBUTIVE METHOD SET FORTH IN 42 CFR 433.68 (e)(1) AND (e)(2), THE STATE DEPARTMENT MAY SEEK A WAIVER FROM THE BROAD-BASED PROVIDER FEES REQUIREMENT OR THE UNIFORM PROVIDER FEES REQUIREMENT, OR BOTH. SUBJECT TO
FEDERAL APPROVAL AND TO MINIMIZE THE FINANCIAL IMPACT ON CERTAIN
HOSPITALS, THE STATE DEPARTMENT, IN CONSULTATION WITH THE
ADVISORY BOARD, MAY EXEMPT FROM PAYMENT OF THE PROVIDER FEE
CERTAIN TYPES OF HOSPITALS, INCLUDING BUT NOT LIMITED TO:

(A) PSYCHIATRIC HOSPITALS, AS LICENSED BY THE DEPARTMENT
OF PUBLIC HEALTH AND ENVIRONMENT;

(B) HOSPITALS THAT ARE LICENSED AS GENERAL HOSPITALS AND
CERTIFIED AS LONG-TERM CARE HOSPITALS BY THE DEPARTMENT OF
PUBLIC HEALTH AND ENVIRONMENT;

(C) CRITICAL ACCESS HOSPITALS THAT ARE LICENSED AS GENERAL
HOSPITALS AND ARE CERTIFIED BY THE DEPARTMENT OF PUBLIC HEALTH
AND ENVIRONMENT UNDER 42 CFR PART 485, SUBPART F;

(D) INPATIENT REHABILITATION FACILITIES; OR

(E) HOSPITALS SPECIFIED FOR EXEMPTION UNDER 42 CFR 433.68
(e).

(II) IN DETERMINING WHETHER A HOSPITAL MAY BE EXCLUDED,
THE STATE DEPARTMENT SHALL USE ONE OR MORE OF THE FOLLOWING
CRITERIA:

(A) A HOSPITAL THAT IS LOCATED IN A RURAL AREA;

(B) A HOSPITAL WITH WHICH THE STATE DEPARTMENT DOES NOT
CONTRACT TO PROVIDE SERVICES UNDER THE STATE MEDICAL ASSISTANCE
PROGRAM;

(C) A HOSPITAL WHOSE INCLUSION OR EXCLUSION WOULD NOT
SIGNIFICANTLY AFFECT THE NET BENEFIT TO HOSPITALS PAYING THE
PROVIDER FEE; OR

(D) A HOSPITAL THAT MUST BE INCLUDED TO RECEIVE FEDERAL
APPROVAL.
(III) THE STATE DEPARTMENT MAY REDUCE THE AMOUNT OF THE PROVIDER FEE FOR CERTAIN HOSPITALS TO OBTAIN FEDERAL APPROVAL AND TO MINIMIZE THE FINANCIAL IMPACT ON CERTAIN HOSPITALS. IN DETERMINING FOR WHICH HOSPITALS THE STATE DEPARTMENT MAY REDUCE THE AMOUNT OF THE PROVIDER FEE, THE STATE DEPARTMENT SHALL USE ONE OR MORE OF THE FOLLOWING CRITERIA:

(A) THE HOSPITAL IS A TYPE OF HOSPITAL DESCRIBED IN SUBPARAGRAPH (I) OF THIS PARAGRAPH (c);

(B) THE HOSPITAL IS LOCATED IN A RURAL AREA;

(C) THE HOSPITAL SERVES A HIGHER PERCENTAGE THAN THE AVERAGE HOSPITAL OF PERSONS COVERED BY THE STATE MEDICAL ASSISTANCE PROGRAM, MEDICARE, OR COMMERCIAL INSURANCE OR PERSONS ENROLLED IN A MANAGED CARE ORGANIZATION;

(D) THE HOSPITAL DOES NOT CONTRACT WITH THE STATE DEPARTMENT TO PROVIDE SERVICES UNDER THE STATE MEDICAL ASSISTANCE PROGRAM;

(E) IF THE HOSPITAL PAID A REDUCED PROVIDER FEE, THE REDUCED PROVIDER FEE WOULD NOT SIGNIFICANTLY AFFECT THE NET BENEFIT TO HOSPITALS PAYING THE PROVIDER FEE; OR

(F) THE HOSPITAL IS REQUIRED NOT TO PAY A REDUCED PROVIDER FEE AS A CONDITION OF FEDERAL APPROVAL.

d) THE STATE DEPARTMENT MAY, WITH THE APPROVAL OF THE ADVISORY BOARD, ALTER THE PROCESS PRESCRIBED IN THIS SECTION TO THE EXTENT NECESSARY TO MEET THE FEDERAL REQUIREMENTS AND TO OBTAIN FEDERAL APPROVAL.

e) (I) THE STATE BOARD, IN CONSULTATION WITH THE ADVISORY BOARD, SHALL PROMULGATE RULES ON THE CALCULATION, ASSESSMENT,
AND TIMING OF THE PROVIDER FEE. THE STATE DEPARTMENT SHALL ASSESS THE PROVIDER FEE ON A SCHEDULE TO BE SET BY THE STATE BOARD THROUGH RULE. THE STATE BOARD RULES SHALL REQUIRE THAT THE PERIODIC PROVIDER FEE PAYMENTS FROM A HOSPITAL AND THE STATE DEPARTMENT'S REIMBURSEMENT TO THE HOSPITAL UNDER SUBPARAGRAPHS (I) AND (II) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION ARE DUE AS NEARLY SIMULTANEOUSLY AS FEASIBLE; EXCEPT THAT THE STATE DEPARTMENT'S REIMBURSEMENT TO THE HOSPITAL SHALL BE DUE NO MORE THAN TWO DAYS AFTER THE PERIODIC PROVIDER FEE PAYMENT IS RECEIVED FROM THE HOSPITAL. THE PROVIDER FEE SHALL BE IMPOSED ON EACH HOSPITAL EVEN IF MORE THAN ONE HOSPITAL IS OWNED BY THE SAME ENTITY. THE FEE SHALL BE PRORATED AND ADJUSTED FOR THE EXPECTED VOLUME OF SERVICE FOR ANY YEAR IN WHICH A HOSPITAL OPENS OR CLOSES.


(III) THE STATE BOARD, IN CONSULTATION WITH THE ADVISORY BOARD, SHALL PROMULGATE RULES ON THE REPORTS THAT HOSPITALS SHALL BE REQUIRED TO SUBMIT FOR THE STATE DEPARTMENT TO CALCULATE THE AMOUNT OF THE PROVIDER FEE. NOTWITHSTANDING THE PROVISIONS OF PART 2 OF ARTICLE 72 OF TITLE 24, C.R.S., INFORMATION PROVIDED TO THE STATE DEPARTMENT PURSUANT TO THIS SECTION SHALL
BE CONSIDERED CONFIDENTIAL AND SHALL NOT BE DEEMED A PUBLIC
RECORD. NONETHELESS, THE STATE DEPARTMENT, IN CONSULTATION
WITH THE ADVISORY BOARD, MAY PREPARE AND RELEASE SUMMARIES OF
THE REPORTS TO THE PUBLIC.

(f) A HOSPITAL SHALL NOT INCLUDE ANY AMOUNT OF THE
PROVIDER FEE AS A SEPARATE LINE ITEM IN ITS BILLING STATEMENTS.

(g) THE STATE BOARD SHALL PROMULGATE ANY RULES PURSUANT
TO THE "STATE ADMINISTRATIVE PROCEDURE ACT", ARTICLE 4 OF TITLE
24, C.R.S., NECESSARY FOR THE ADMINISTRATION AND IMPLEMENTATION
OF THIS SECTION. PRIOR TO SUBMITTING ANY PROPOSED RULES
CONCERNING THE ADMINISTRATION OR IMPLEMENTATION OF THE
PROVIDER FEE TO THE STATE BOARD, THE STATE DEPARTMENT SHALL
CONSULT WITH THE ADVISORY BOARD ON THE PROPOSED RULES AS
SPECIFIED IN PARAGRAPH (e) OF SUBSECTION (6) OF THIS SECTION.

(4) **Hospital provider fee cash fund.** (a) ALL PROVIDER FEES
COLLECTED PURSUANT TO THIS SECTION BY THE STATE DEPARTMENT
SHALL BE TRANSMITTED TO THE STATE TREASURER, WHO SHALL CREDIT
THE SAME TO THE HOSPITAL PROVIDER FEE CASH FUND, WHICH FUND IS
HEREBY CREATED AND REFERRED TO IN THIS SECTION AS THE "FUND".

(b) ALL MONEYS IN THE FUND SHALL BE SUBJECT TO FEDERAL
MATCHING AS AUTHORIZED UNDER FEDERAL LAW AND SUBJECT TO
ANNUAL APPROPRIATION BY THE GENERAL ASSEMBLY FOR THE FOLLOWING
PURPOSES:

(I) TO MAXIMIZE THE INPATIENT AND OUTPATIENT HOSPITAL
REIMBURSEMENTS TO UP TO THE UPPER PAYMENT LIMITS AS DEFINED IN 42
CFR 447.272 AND 42 CFR 447.321;

(II) TO INCREASE HOSPITAL REIMBURSEMENTS UNDER THE
COLORADO INDIGENT CARE PROGRAM TO UP TO ONE HUNDRED PERCENT
OF THE HOSPITAL'S COSTS OF PROVIDING MEDICAL CARE UNDER THE
PROGRAM;

(III) TO PAY THE QUALITY INCENTIVE PAYMENTS PROVIDED IN
SECTION 25.5-4-402 (3);

(IV) SUBJECT TO AVAILABLE REVENUE FROM THE PROVIDER FEE
AND FEDERAL MATCHING FUNDS, TO EXPAND ELIGIBILITY FOR PUBLIC
MEDICAL ASSISTANCE BY:

(A) INCREASING THE ELIGIBILITY LEVEL FOR PARENTS OF
CHILDREN WHO ARE ELIGIBLE FOR MEDICAL ASSISTANCE OR THE
CHILDREN'S BASIC HEALTH PLAN TO UP TO ONE HUNDRED PERCENT OF THE
FEDERAL POVERTY LEVEL;

(B) INCREASING THE ELIGIBILITY LEVEL FOR CHILDREN AND
PREGNANT WOMEN UNDER THE CHILDREN'S BASIC HEALTH PLAN TO UP TO
TWO HUNDRED FIFTY PERCENT OF THE FEDERAL POVERTY LEVEL;

(C) PROVIDING ELIGIBILITY UNDER THE STATE MEDICAL
ASSISTANCE PROGRAM FOR A CHILDLESS ADULT OR ADULTS WITHOUT A
DEPENDENT CHILD IN THE HOME WHO EARNS UP TO ONE HUNDRED
PERCENT OF THE FEDERAL POVERTY LEVEL;

(D) PROVIDING A BUY-IN PROGRAM IN THE STATE MEDICAL
ASSISTANCE PROGRAM FOR DISABLED ADULTS AND CHILDREN WHOSE
FAMILIES EARN UP TO FOUR HUNDRED PERCENT OF THE FEDERAL POVERTY
LEVEL;

(V) TO PROVIDE CONTINUOUS ELIGIBILITY FOR TWELVE MONTHS
FOR CHILDREN ENROLLED IN THE STATE MEDICAL ASSISTANCE PROGRAM;

(VI) TO PAY THE STATE DEPARTMENT'S ACTUAL ADMINISTRATIVE
COSTS OF IMPLEMENTING AND ADMINISTERING THIS SECTION, INCLUDING
BUT NOT LIMITED TO THE FOLLOWING COSTS:

(A) EXPENSES OF THE ADVISORY BOARD, INCLUDING BUT NOT LIMITED TO THE STATE DEPARTMENT’S PERSONAL SERVICES AND OPERATING COSTS RELATED TO THE ADMINISTRATION OF THE ADVISORY BOARD;

(B) THE STATE DEPARTMENT’S ACTUAL COSTS RELATED TO IMPLEMENTING AND MAINTAINING THE PROVIDER FEE, INCLUDING PERSONAL SERVICES, OPERATING, AND CONSULTING EXPENSES;

(C) THE STATE DEPARTMENT’S ACTUAL COSTS FOR THE CHANGES AND UPDATES TO THE MEDICAID MANAGEMENT INFORMATION SYSTEM FOR THE IMPLEMENTATION OF SUBPARAGRAPHS (I) TO (III) OF THIS PARAGRAPH (b);

(D) THE STATE DEPARTMENT’S PERSONAL SERVICES AND OPERATING COSTS RELATED TO PERSONNEL, CONSULTING SERVICES, AND FOR REVIEW OF HOSPITAL COSTS NECESSARY TO IMPLEMENT AND ADMINISTER THE INCREASES IN INPATIENT AND OUTPATIENT HOSPITAL PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (I) OF THIS PARAGRAPH (b), INCREASES IN THE COLORADO INDIGENT CARE PROGRAM PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (II) OF THIS PARAGRAPH (b), AND QUALITY INCENTIVE PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (III) OF THIS PARAGRAPH (b);

(E) THE STATE DEPARTMENT’S ACTUAL COSTS FOR THE CHANGES AND UPDATES TO THE COLORADO BENEFITS MANAGEMENT SYSTEM AND MEDICAID MANAGEMENT INFORMATION SYSTEM TO IMPLEMENT AND MAINTAIN THE EXPANDED ELIGIBILITY PROVIDED FOR IN SUBPARAGRAPHS (IV) AND (V) OF THIS PARAGRAPH (b);

(F) THE STATE DEPARTMENT’S PERSONAL SERVICES AND
OPERATING COSTS RELATED TO PERSONNEL NECESSARY TO IMPLEMENT
AND ADMINISTER THE EXPANDED ELIGIBILITY FOR PUBLIC MEDICAL
ASSISTANCE PROVIDED FOR IN SUBPARAGRAPHS (IV) AND (V) OF THIS
PARAGRAPH (b);

(G) THE STATE DEPARTMENT'S PERSONAL SERVICES, OPERATING,
AND SYSTEMS COSTS RELATED TO EXPANDING THE OPPORTUNITY FOR
INDIVIDUALS TO APPLY FOR PUBLIC MEDICAL ASSISTANCE DIRECTLY AT
HOSPITALS OR THROUGH ANOTHER ENTITY OUTSIDE THE COUNTY
DEPARTMENTS THAT WOULD INCREASE ACCESS TO PUBLIC MEDICAL
ASSISTANCE AND REDUCE THE NUMBER OF UNINSURED SERVED BY
HOSPITALS;

(H) THE STATE DEPARTMENT'S PERSONAL SERVICES, OPERATING,
AND SYSTEMS COSTS RELATED TO THE ESTABLISHMENT OF
OUTCOMES-BASED PRACTICES AND INTENSIVE CARE COORDINATION,
WHICH INCLUDES DATA SHARING BETWEEN HOSPITAL PROVIDERS AND
OTHER MEDICAL PROVIDERS, TO REDUCE HOSPITAL COSTS RELATED TO
INAPPROPRIATE OUTPATIENT SERVICES, TO REDUCE EMERGENCY ROOM
UTILIZATION FOR CONDITIONS THAT CAN BE TREATED IN AN OUTPATIENT
SETTING, AND TO REDUCE AVOIDABLE, PREVENTABLE, AND INAPPROPRIATE
INPATIENT HOSPITALIZATIONS; AND

(VII) TO OFFSET THE LOSS OF ANY FEDERAL MATCHING FUNDS DUE
TO A DECREASE IN THE CERTIFICATION OF THE PUBLIC EXPENDITURE
PROCESS FOR OUTPATIENT HOSPITAL SERVICES FOR MEDICAL SERVICES
PREMIUMS THAT WERE IN EFFECT AS OF JULY 1, 2008.

(c) ANY MONEYS IN THE FUND NOT EXPENDED FOR THE PURPOSES
DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (4) MAY BE INVESTED
BY THE STATE TREASURER AS PROVIDED BY LAW. ALL INTEREST AND
INCOME DERIVED FROM THE INVESTMENT AND DEPOSIT OF MONEYS IN THE FUND SHALL BE CREDITED TO THE FUND. ANY UNEXPENDED AND UNENCUMBERED MONEYS REMAINING IN THE FUND AT THE END OF ANY FISCAL YEAR SHALL REMAIN IN THE FUND AND SHALL NOT BE CREDITED OR TRANSFERRED TO THE GENERAL FUND OR ANY OTHER FUND BUT SHALL BE APPROPRIATED BY THE GENERAL ASSEMBLY FOR THE PURPOSES DESCRIBED IN PARAGRAPH (b) OF THIS SUBSECTION (4) IN FUTURE FISCAL YEARS.

(5) **Appropriations.** (a)(I) The provider fee is to supplement, not supplant, general fund appropriations to support hospital reimbursements as of the effective date of this section. General fund appropriations for hospital reimbursements shall be maintained at the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008; except that general fund appropriations for hospital reimbursements may be reduced if an index of appropriations to other providers shows that general fund appropriations are reduced for other providers. If the index shows that general fund appropriations are reduced for other providers, the general fund appropriations for hospital reimbursements shall not be reduced by a greater percentage than the reductions of appropriations for the other providers as shown by the index.

(II) If general fund appropriations for hospital reimbursements are reduced below the level of appropriations in the medical services premium line item made for the fiscal year commencing July 1, 2008, the general fund appropriations will be increased back to the level of appropriations in the medical services premium line item made for the fiscal year.
COMMENCING JULY 1, 2008, AT THE SAME PERCENTAGE AS THE
APPROPRIATIONS FOR OTHER PROVIDERS AS SHOWN BY THE INDEX. THE
GENERAL ASSEMBLY IS NOT OBLIGATED TO INCREASE THE GENERAL FUND
APPROPRIATIONS BACK TO THE LEVEL OF APPROPRIATIONS IN THE MEDICAL
SERVICES PREMIUM LINE ITEM IN A SINGLE FISCAL YEAR AND SUCH
INCREASES MAY OCCUR OVER NONCONSECUTIVE FISCAL YEARS.

(III) FOR PURPOSES OF THIS PARAGRAPH (a), THE "INDEX OF
APPROPRIATIONS TO OTHER PROVIDERS" OR "INDEX" SHALL MEAN THE
AVERAGE PERCENT CHANGE IN REIMBURSEMENT RATES THROUGH
APPROPRIATIONS OR LEGISLATION ENACTED BY THE GENERAL ASSEMBLY
TO HOME HEALTH PROVIDERS, PHYSICIAN SERVICES, AND OUTPATIENT
PHARMACIES, EXCLUDING DISPENSING FEES. THE STATE BOARD, AFTER
CONSULTATION WITH THE ADVISORY BOARD, IS AUTHORIZED TO CLARIFY
THIS DEFINITION AS NECESSARY BY RULE.

(b) IF THE REVENUE FROM THE PROVIDER FEE IS INSUFFICIENT TO
FULLY FUND ALL OF THE PURPOSES DESCRIBED IN PARAGRAPH (b) OF
SUBSECTION (4) OF THIS SECTION:

(I) THE GENERAL ASSEMBLY IS NOT OBLIGATED TO APPROPRIATE
GENERAL FUND REVENUES TO FUND SUCH PURPOSES;

(II) THE HOSPITAL PROVIDER REIMBURSEMENT AND QUALITY
INCENTIVE PAYMENT INCREASES DESCRIBED IN SUBPARAGRAPHS (I) TO
(III) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION AND THE
COSTS DESCRIBED IN SUBPARAGRAPHS (VI) AND (VII) OF PARAGRAPH (b)
OF SUBSECTION (4) OF THIS SECTION SHALL BE FULLY FUNDED USING
REVENUE FROM THE PROVIDER FEE AND FEDERAL MATCHING FUNDS
BEFORE ANY ELIGIBILITY EXPANSION IS FUNDED; AND

(III) (A) IF THE STATE BOARD PROMULGATES RULES THAT EXPAND
ELIGIBILITY FOR MEDICAL ASSISTANCE TO BE PAID FOR PURSUANT TO
SUBPARAGRAPH (IV) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS
SECTION, AND THE STATE DEPARTMENT THEREAFTER NOTIFIES THE
ADVISORY BOARD THAT THE REVENUE AVAILABLE FROM THE PROVIDER
FEE AND THE FEDERAL MATCHING FUNDS WILL NOT BE SUFFICIENT TO PAY
FOR ALL OR PART OF THE EXPANDED ELIGIBILITY, THE ADVISORY BOARD
SHALL RECOMMEND TO THE STATE BOARD REDUCTIONS IN MEDICAL
BENEFITS OR ELIGIBILITY SO THAT THE REVENUE WILL BE SUFFICIENT TO
PAY FOR ALL OF THE REDUCED BENEFITS OR ELIGIBILITY. AFTER
RECEIVING THE RECOMMENDATIONS OF THE ADVISORY BOARD, THE STATE
BOARD SHALL ADOPT RULES PROVIDING FOR REDUCED BENEFITS OR
REDUCED ELIGIBILITY FOR WHICH THE REVENUE SHALL BE SUFFICIENT AND
SHALL FORWARD ANY ADOPTED RULES TO THE JOINT BUDGET COMMITTEE.
NOTWITHSTANDING THE PROVISIONS OF SECTION 24-4-103 (8) AND (12),
C.R.S., FOLLOWING THE ADOPTION OF RULES PURSUANT TO THIS
SUB-SUBPARAGRAPH (A), THE STATE BOARD SHALL NOT SUBMIT THE
RULES TO THE ATTORNEY GENERAL AND SHALL NOT FILE THE RULES WITH
THE SECRETARY OF STATE UNTIL THE JOINT BUDGET COMMITTEE APPROVES
THE RULES PURSUANT TO SUB-SUBPARAGRAPH (B) OF THIS SUBPARAGRAPH
(III).

(B) THE JOINT BUDGET COMMITTEE SHALL PROMPTLY CONSIDER
ANY RULES ADOPTED BY THE STATE BOARD PURSUANT TO
SUB-SUBPARAGRAPH (A) OF THIS SUBPARAGRAPH (III). THE JOINT BUDGET
COMMITTEE SHALL PROMPTLY NOTIFY THE STATE DEPARTMENT, THE
STATE BOARD, AND THE ADVISORY BOARD OF ANY ACTION ON SUCH RULES.
IF THE JOINT BUDGET COMMITTEE DOES NOT APPROVE THE RULES, THE
JOINT BUDGET COMMITTEE SHALL RECOMMEND A REDUCTION IN BENEFITS
OR ELIGIBILITY SO THAT THE REVENUE FROM THE PROVIDER FEE AND THE
MATCHING FEDERAL FUNDS WILL BE SUFFICIENT TO PAY FOR THE REDUCED
BENEFITS OR ELIGIBILITY. AFTER APPROVING THE RULES PURSUANT TO
THIS SUB-SUBPARAGRAPH (B), THE JOINT BUDGET COMMITTEE SHALL
REQUEST THAT THE COMMITTEE ON LEGAL SERVICES, CREATED PURSUANT
TO SECTION 2-3-501, C.R.S., EXTEND THE RULES AS PROVIDED FOR IN
SECTION 24-4-103 (8), C.R.S., UNLESS THE COMMITTEE ON LEGAL
SERVICES FINDS AFTER REVIEW THAT THE RULES DO NOT CONFORM WITH
SECTION 24-4-103 (8) (a), C.R.S.

(C) AFTER THE STATE BOARD HAS RECEIVED NOTIFICATION OF THE
APPROVAL OF RULES ADOPTED PURSUANT TO SUB-SUBPARAGRAPH (A) OF
THIS SUBPARAGRAPH (III), THE STATE BOARD SHALL SUBMIT THE RULES TO
THE ATTORNEY GENERAL PURSUANT TO SECTION 24-4-103 (8) (b), C.R.S.,
AND SHALL FILE THE RULES AND THE OPINION OF THE ATTORNEY GENERAL
WITH THE SECRETARY OF STATE PURSUANT TO SECTION 24-4-103 (12),
C.R.S., AND WITH THE OFFICE OF LEGISLATIVE LEGAL SERVICES.
PURSUANT TO SECTION 24-4-103 (5), C.R.S., THE RULES SHALL BE
EFFECTIVE TWENTY DAYS AFTER PUBLICATION OF THE RULES AND SHALL
ONLY BE EFFECTIVE UNTIL THE FOLLOWING MAY 15 UNLESS THE RULES
ARE EXTENDED PURSUANT TO A BILL ENACTED PURSUANT TO SECTION
24-4-103 (8), C.R.S.

(c) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION,
IF, AFTER RECEIPT OF AUTHORIZATION TO RECEIVE FEDERAL MATCHING
FUNDS FOR MONEYS IN THE FUND, THE AUTHORIZATION IS WITHDRAWN OR
CHANGED SO THAT FEDERAL MATCHING FUNDS ARE NO LONGER
AVAILABLE, THE STATE DEPARTMENT SHALL CEASE COLLECTING THE
 PROVIDER FEE AND SHALL REPAY TO THE HOSPITALS ANY MONEYS
RECEIVED BY THE FUND THAT ARE NOT SUBJECT TO FEDERAL MATCHING FUNDS.

(6) Hospital provider fee oversight and advisory board.

(a) There is hereby created in the state department the hospital provider fee oversight and advisory board, referred to in this section as the "advisory board".

(b)(1) The advisory board shall consist of eleven members appointed by the governor, with the advice and consent of the senate, as follows:

(A) Four members who are employed by hospitals in Colorado, including at least one person who is employed by a hospital in a rural area, one person who is employed by a safety-net hospital for which the percent of medicaid-eligible inpatient days relative to its total inpatient days shall be equal to or greater than one standard deviation above the mean, and one person who is employed by a hospital in an urban area;

(B) One member who is a representative of a statewide organization of hospitals;

(C) One member who represents a statewide organization of health insurance companies or a health insurance company licensed pursuant to title 10, C.R.S., and who is not a representative of a hospital;

(D) One member of the health care industry who does not represent a hospital or a health insurance company;

(E) One member who is a consumer of health care and who is not a representative or an employee of a hospital, health insurance company, or other health care industry entity;
(F) One member who is a representative of a business that purchases health insurance for its employees; and

(G) Two employees of the state department.

(II) The governor shall consult with representatives of a statewide organization of hospitals in making the appointments pursuant to sub-subparagraphs (A) and (B) of subparagraph (I) of this paragraph (b). No more than six members of the advisory board may be members of the same political party.

(III) Members of the advisory board shall serve at the pleasure of the governor. In making the appointments, the governor shall specify that four members shall serve initial terms of two years and three members shall serve initial terms of three years. All other terms including terms after the initial terms shall be four years. A member who is appointed to fill a vacancy shall serve the remainder of the unexpired term of the former member.

(IV) The governor shall designate a chair from among the members of the advisory board appointed pursuant to sub-subparagraphs (A) to (F) of subparagraph (I) of this paragraph (b). The advisory board shall elect a vice-chair from among its members.

(c) Members of the advisory board shall serve without compensation but shall be reimbursed from moneys in the fund for actual and necessary expenses incurred in the performance of their duties pursuant to this section.

(d) The advisory board may direct the state department
TO CONTRACT FOR A GROUP FACILITATOR TO ASSIST THE MEMBERS OF THE
ADVISORY BOARD IN PERFORMING THEIR REQUIRED DUTIES.

(e) The advisory board shall have, at a minimum, the
following duties:

(I) To recommend to the state department the timing and
method by which the state department shall assess the provider
fee and the amount of the fee;

(II) If requested by the health and human services
committees of the senate or house of representatives, or any
successor committees, to consult with the committees on any
legislation that may impact the provider fee or hospital
reimbursements established pursuant to this section;

(III) To recommend to the state department changes in the
provider fee that increase the number of hospitals benefitting
from the uses of the provider fee described in subparagraphs (I)
to (V) of paragraph (b) of subsection (4) of this section or that
minimize the number of hospitals that suffer losses as a result
of paying the provider fee;

(IV) To recommend to the state department reforms or
changes to the inpatient hospital and outpatient hospital
reimbursements and quality incentive payments made under the
state medical assistance program to increase provider
accountability, performance, and reporting;

(V) To recommend to the state department the schedule
and approach to the implementation of subparagraphs (IV) and
(V) of paragraph (b) of subsection (4) of this section;

(VI) If moneys in the fund are insufficient to fully fund
ALL OF THE PURPOSES SPECIFIED IN PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION, TO RECOMMEND TO THE STATE BOARD CHANGES TO THE EXPANDED ELIGIBILITY PROVISIONS DESCRIBED IN SUBPARAGRAPH (IV) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;

(VII) TO PREPARE THE REPORTS SPECIFIED IN PARAGRAPH (f) OF THIS SUBSECTION (6);

(VIII) TO MONITOR THE IMPACT OF THE HOSPITAL PROVIDER FEE ON THE BROADER HEALTH CARE MARKETPLACE; AND

(IX) TO PERFORM ANY OTHER DUTIES REQUIRED TO FULFILL THE ADVISORY BOARD'S CHARGE OR THOSE ASSIGNED TO IT BY THE STATE BOARD OR THE EXECUTIVE DIRECTOR.


(I) THE RECOMMENDATIONS MADE TO THE STATE BOARD PURSUANT TO THIS SECTION;

(II) AN ITEMIZATION OF THE TOTAL AMOUNT OF THE PROVIDER FEE PAID BY EACH HOSPITAL AND ANY PROJECTED REVENUE THAT EACH HOSPITAL IS EXPECTED TO RECEIVE DUE TO:

(A) THE INCREASED REIMBURSEMENTS MADE PURSUANT TO SUBPARAGRAPHS (I) AND (II) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION AND THE QUALITY INCENTIVE PAYMENTS MADE PURSUANT TO SUBPARAGRAPH (III) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS
SECTION; AND

(B) THE INCREASED ELIGIBILITY DESCRIBED IN SUBPARAGRAPHS

(IV) AND (V) OF PARAGRAPH (b) OF SUBSECTION (4) OF THIS SECTION;

(III) AN ITEMIZATION OF THE COSTS INCURRED BY THE STATE

DEPARTMENT IN IMPLEMENTING AND ADMINISTERING THE HOSPITAL

PROVIDER FEE; AND

(IV) ESTIMATES OF THE DIFFERENCES BETWEEN THE COST OF CARE

PROVIDED AND THE PAYMENT RECEIVED BY HOSPITALS ON A PER-PATIENT

BASIS, AGGREGATED FOR ALL HOSPITALS, FOR PATIENTS COVERED BY EACH

OF THE FOLLOWING:

(A) MEDICAID;

(B) MEDICARE; AND

(C) ALL OTHERS PAYERS.

(g) (I) THIS SUBSECTION (6) IS REPEALED, EFFECTIVE JULY 1, 2019.

(II) PRIOR TO SAID REPEAL, THE ADVISORY BOARD SHALL BE

REVIEWED AS PROVIDED IN SECTION 2-3-1203, C.R.S.

(7) Notice to revisor of statutes - repeal. (a) WITHIN SIXTY

DAYS AFTER THE STATE DEPARTMENT RECEIVES AUTHORIZATION TO

RECEIVE FEDERAL MATCHING FUNDS FOR THE MONEYS IN THE FUND, THE

EXECUTIVE DIRECTOR SHALL SEND WRITTEN NOTICE TO THE REVISOR OF

STATUTES AND TO THE STATE TREASURER INFORMING THEM OF THE

AUTHORIZATION.

(b) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (3) OF

THIS SECTION, IF THE STATE TREASURER HAS NOT RECEIVED THE NOTICE

REQUIRED BY PARAGRAPH (a) OF THIS SUBSECTION (7) BY JULY 1, 2011,

THE STATE TREASURER SHALL RETURN ALL MONEYS CONTAINED IN THE

FUND TO THE HOSPITALS THAT PAID THE PROVIDER FEE, TOGETHER WITH
ANY INTEREST OR INCOME EARNED ON SUCH MONEYS.

(c) IF THE REVISOR OF STATUTES DOES NOT RECEIVE THE NOTICE REQUIRED BY PARAGRAPH (a) OF THIS SUBSECTION (7) BY JULY 1, 2012, THIS SECTION IS REPEALED, EFFECTIVE JULY 1, 2012.

(d) IF THE REVISOR OF STATUTES RECEIVES THE NOTICE REQUIRED BY PARAGRAPH (a) OF THIS SUBSECTION (7), THIS SUBSECTION (7) IS REPEALED, EFFECTIVE JULY 1 OF THE YEAR FOLLOWING THE RECEIPT OF THE NOTICE.

SECTION 2. 2-3-1203 (3), Colorado Revised Statues, is amended BY THE ADDITION OF A NEW PARAGRAPH to read:

2-3-1203. Sunset review of advisory committees. (3) The following dates are the dates for which the statutory authorization for the designated advisory committees is scheduled for repeal:

(ff) JULY 1, 2019: THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD, CREATED IN SECTION 25.5-4-402.3, C.R.S.

SECTION 3. 25.5-3-108, Colorado Revised Statutes, is amended BY THE ADDITION OF A NEW SUBSECTION to read:

25.5-3-108. Responsibility of the department of health care policy and financing - provider reimbursement. (17) PURSUANT TO
FUNDING MADE AVAILABLE UNDER SECTION 25.5-4-402.3, THE STATE DEPARTMENT SHALL INCREASE HOSPITAL REIMBURSEMENTS UP TO ONE HUNDRED PERCENT OF HOSPITAL COSTS FOR PROVIDING MEDICAL CARE UNDER THE PROGRAM.

SECTION 4. 25.5-4-402 (1), Colorado Revised Statutes, is amended, and the said 25.5-4-402 is further amended BY THE ADDITION OF A NEW SUBSECTION, to read:

25.5-4-402. Providers - hospital reimbursement - rules.
(1) For all licensed or certified hospitals contracting for services under this article and articles 5 and 6 of this title, except those hospitals operated by the department of human services or those hospitals deemed exempt by the state board, the state department shall pay all licensed or certified hospitals under this article and articles 5 and 6 of this title, except those hospitals operated by the department of human services, for inpatient hospital services pursuant to a system of prospective payment, generally based on the elements of the Medicare system of a diagnosis-related groups system. The state department shall develop and administer a system for ensuring appropriate utilization and quality of care provided by those providers who are reimbursed pursuant to the system of prospective payment developed under this section. Subject to available appropriations, the state department may also make supplemental Medicaid payments to certain hospitals. The state board shall promulgate rules to provide for the implementation of this section.

(3) (a) In addition to the reimbursement rate process described in subsection (1) of this section and subject to funding made available pursuant to section 25.5-4-402.3, the state department shall pay an additional amount based upon performance to those hospitals that provide services that improve health care outcomes for their patients. This amount shall be determined by the state department based upon nationally recognized performance measures established in rules adopted by the state board. The state quality standards shall be consistent with federal quality standards published by...
AN ORGANIZATION WITH EXPERTISE IN HEALTH CARE QUALITY, INCLUDING
BUT NOT LIMITED TO, THE CENTERS FOR MEDICARE AND MEDICAID
SERVICES, THE AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, OR
THE NATIONAL QUALITY FORUM.

(b) THE AMOUNT OF THE PAYMENTS MADE PURSUANT TO THIS
SUBSECTION (3) SHALL BE COMPUTED ANNUALLY. FOR THE FIRST TWO
FISCAL YEARS THAT PAYMENTS ARE MADE PURSUANT TO THIS SUBSECTION
(3), THE TOTAL AMOUNT OF THE PAYMENTS SHALL BE UP TO FIVE PERCENT
OF THE TOTAL REIMBURSEMENTS MADE TO HOSPITALS IN THE PREVIOUS
YEAR. FOR EACH FISCAL YEAR AFTER THE FIRST TWO FISCAL YEARS, THE
TOTAL AMOUNT OF THE PAYMENTS SHALL BE UP TO SEVEN PERCENT OF THE
TOTAL REIMBURSEMENTS MADE TO HOSPITALS IN THE PREVIOUS YEAR.

SECTION 5. 25.5-5-201 (1) (m) (I) and (1) (o), Colorado
Revised Statutes, are amended, and the said 25.5-5-201 (1) is further
amended BY THE ADDITION OF THE FOLLOWING NEW
PARAGRAPHS, to read:

25.5-5-201. Optional provisions - optional groups. (1) The
federal government allows the state to select optional groups to receive
medical assistance. Pursuant to federal law, any person who is eligible
for medical assistance under the optional groups specified in this section
shall receive both the mandatory services specified in sections 25.5-5-102
and 25.5-5-103 and the optional services specified in sections 25.5-5-202
and 25.5-5-203. Subject to the availability of federal financial aid funds,
the following are the individuals or groups that Colorado has selected as
optional groups to receive medical assistance pursuant to this article and
articles 4 and 6 of this title:

(m) (I) (A) Parents of children who are eligible for the medical
assistance program or the children's basic health plan, article 8 of this
title, whose family income does not exceed a specified percent of the
federal poverty level, adjusted for family size, as set by the state board by
rule, which percentage shall be not less than sixty one hundred percent.

(B) Notwithstanding the provisions of sub-subparagraph
(A) of this subparagraph (I), if the moneys in the hospital
provider fee cash fund established pursuant to section
25.5-4-402.3 (4), together with the corresponding federal
matching funds, are insufficient to fully fund all of the
purposes described in section 25.5-4-402.3 (4) (b), after receiving
recommendations from the hospital provider fee oversight and
advisory board established pursuant to section 25.5-4-402.3 (6),
for parents of children eligible for the medical assistance
program or the children's basic health plan, the state board by
rule adopted pursuant to the provisions of section 25.5-4-402.3
(5) (b) (III) may reduce the medical benefits offered or the
percentage of the federal poverty level to below one hundred
percent, but the percentage shall not be reduced to below sixty
percent.

(o) (I) Individuals with disabilities who are participating in the
medicaid buy-in program established in part 14 of article 6 of this title.

(II) Notwithstanding the provisions of subparagraph (I) of
this paragraph (o), if the moneys in the hospital provider fee cash
fund established pursuant to section 25.5-4-402.3 (4), together
with the corresponding federal matching funds, are insufficient
to fully fund all of the purposes described in section 25.5-4-402.3
(4) (b), after receiving recommendations from the hospital
PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (6), FOR INDIVIDUALS WITH DISABILITIES WHO ARE PARTICIPATING IN THE MEDICAID BUY-IN PROGRAM ESTABLISHED IN PART 14 OF ARTICLE 6 OF THIS TITLE, THE STATE BOARD BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY REDUCE THE MEDICAL BENEFITS OFFERED OR THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL TO BELOW FOUR HUNDRED PERCENT OR MAY ELIMINATE THIS ELIGIBILITY GROUP.

(p) (I) SUBJECT TO FEDERAL APPROVAL, PERSONS OVER EIGHTEEN YEARS OF AGE WHO ARE CHILDLESS OR WITHOUT A DEPENDENT CHILD IN THE HOME WHOSE FAMILY INCOME DOES NOT EXCEED A SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY LEVEL, ADJUSTED FOR FAMILY SIZE AND AS SET BY THE STATE BOARD BY RULE, WHICH PERCENTAGE SHALL BE NOT LESS THAN ONE HUNDRED PERCENT.

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (p), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (6), FOR CHILDLESS PERSONS OR FOR PERSONS WITHOUT A DEPENDENT CHILD IN THE HOME, THE STATE BOARD BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY REDUCE THE MEDICAL BENEFITS OFFERED OR THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL TO BELOW ONE HUNDRED PERCENT OR MAY ELIMINATE THIS ELIGIBILITY GROUP.
CHILDREN WHO ARE CONTINUOUSLY ELIGIBLE FOR TWELVE MONTHS PURSUANT TO SECTION 25.5-5-204.5.

PERSONS ELIGIBLE FOR A MEDICAID BUY-IN PROGRAM ESTABLISHED PURSUANT TO SECTION 25.5-5-206 WHOSE FAMILY INCOME DOES NOT EXCEED A SPECIFIED PERCENTAGE OF THE FEDERAL POVERTY LEVEL, ADJUSTED FOR FAMILY SIZE AND AS SET BY THE STATE BOARD BY RULE, WHICH PERCENTAGE SHALL BE NOT MORE THAN FOUR HUNDRED PERCENT.

NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (r), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (6), FOR PERSONS ELIGIBLE FOR A MEDICAID BUY-IN PROGRAM ESTABLISHED PURSUANT TO SECTION 25.5-5-206, THE STATE BOARD BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY REDUCE THE MEDICAL BENEFITS OFFERED, OR THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL, OR MAY ELIMINATE THIS ELIGIBILITY GROUP.

SECTION 6. Part 2 of article 5 of title 25.5, Colorado Revised Statutes, is amended BY THE ADDITION OF THE FOLLOWING NEW SECTIONS to read:

25.5-5-204.5. Continuous eligibility - children. (1) A CHILD WHO IS DETERMINED TO BE ELIGIBLE FOR BENEFITS UNDER THIS ARTICLE OR UNDER ARTICLE 4 OR 6 OF THIS TITLE SHALL REMAIN ELIGIBLE FOR
TWELVE MONTHS SUBSEQUENT TO THE LAST DAY OF THE MONTH IN WHICH
THE CHILD WAS ENROLLED; EXCEPT THAT A CHILD SHALL NO LONGER BE
ELIGIBLE AND SHALL BE DISENROLLED FROM THE STATE MEDICAL
ASSISTANCE PROGRAM IF THE STATE DEPARTMENT BECOMES AWARE OF OR
IS NOTIFIED THAT THE CHILD HAS MOVED OUT OF THE STATE OR HAS
REACHED NINTEEN YEARS OF AGE.

(2) NOTWITHSTANDING THE PROVISIONS OF SUBSECTION (1) OF
THIS SECTION, IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND
ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH
THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO
FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4)
(b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER
FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO
SECTION 25.5-4-402.3 (6), THE STATE BOARD BY RULE ADOPTED PURSUANT TO
THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY ELIMINATE
THE CONTINUOUS ENROLLMENT REQUIREMENT PURSUANT TO THIS
SECTION.

25.5-5-206. Medicaid buy-in program - disabled children -
disabled adults - federal authorization - rules. (1) (a) SUBJECT TO
AVAILABLE APPROPRIATIONS, THE STATE DEPARTMENT IS AUTHORIZED TO
SEEK FEDERAL AUTHORIZATION TO AND TO ESTABLISH A MEDICAID BUY IN
PROGRAM OR PROGRAMS FOR:

(I) DISABLED CHILDREN; OR

(II) DISABLED ADULTS WHO DO NOT QUALIFY FOR THE MEDICAID
BUY-IN PROGRAM ESTABLISHED PURSUANT TO PART 14 OF ARTICLE 6 OF
THIS TITLE.

(b) THE MEDICAID BUY-IN PROGRAM OR PROGRAMS ESTABLISHED
PURSUANT TO PARAGRAPH (a) OF THIS SUBSECTION (1) MAY PROVIDE FOR PREMIUM AND COST-SHARING CHARGES ON A SLIDING FEE SCALE BASED UPON A FAMILY'S INCOME.

(2) THE STATE BOARD SHALL PROMULGATE RULES CONSISTENT WITH ANY FEDERAL AUTHORIZATION TO IMPLEMENT AND ADMINISTER THE MEDICAID BUY-IN PROGRAM OR PROGRAMS ESTABLISHED PURSUANT TO PARAGRAPH (a) OF SUBSECTION (1) OF THIS SECTION.

SECTION 7. 25.5-6-1403 (2), Colorado Revised Statutes, is amended to read:

25.5-6-1403. Waivers and amendments. (2) If approved by the joint budget committee following its review of the report and subject to available appropriations, the state department shall submit to the federal health care financing administration CENTERS FOR MEDICARE AND MEDICAID SERVICES an amendment to the state medical assistance plan, and shall request any necessary waivers from the secretary of the federal department of health and human services, to permit the state department to expand medical assistance eligibility as provided in this part 14 for the purpose of implementing a medicaid buy-in program for people with disabilities who are in the basic coverage group or the medical improvement group. In addition, the state department shall apply to the secretary of the federal department of health and human services for a medicaid infrastructure grant, if available, to develop and implement the federal "Ticket to Work and Work Incentives Improvement Act of 1999", Pub.L. 106-170.

SECTION 8. 25.5-8-103 (4) (a), Colorado Revised Statutes, as it will become effective March 1, 2009, is amended to read:

25.5-8-103. Definitions. As used in this article, unless the context
otherwise requires:

(4) "Eligible person" means:

(a) (I) A person who is less than nineteen years of age, whose family income does not exceed two hundred twenty-five percent of the federal poverty level, adjusted for family size; except that, subject to available appropriations, the department may increase the percentage of the federal poverty level for purposes of eligibility to up to two hundred fifty percent; or

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (a), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (6), FOR PERSONS LESS THAN NINETEEN YEARS OF AGE, THE STATE BOARD MAY BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) REDUCE THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL TO BELOW TWO HUNDRED FIFTY PERCENT, BUT THE PERCENTAGE SHALL NOT BE REDUCED TO BELOW TWO HUNDRED TWENTY-FIVE PERCENT; OR

SECTION 9. 25.5-8-103 (4) (b), Colorado Revised Statutes, as it will become effective October 1, 2009, is amended to read:

25.5-8-103. Definitions. As used in this article, unless the context otherwise requires:

(4) "Eligible person" means:

(b) (I) A pregnant woman whose family income does not exceed
two hundred twenty-five FIFTY percent of the federal poverty level, adjusted for family size, and who is not eligible for medicaid. except that, subject to available appropriations, the department may increase the percentage of the federal poverty level for purposes of eligibility to up to two hundred fifty percent.

(II) NOTWITHSTANDING THE PROVISIONS OF SUBPARAGRAPH (I) OF THIS PARAGRAPH (b), IF THE MONEYS IN THE HOSPITAL PROVIDER FEE CASH FUND ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (4), TOGETHER WITH THE CORRESPONDING FEDERAL MATCHING FUNDS, ARE INSUFFICIENT TO FULLY FUND ALL OF THE PURPOSES DESCRIBED IN SECTION 25.5-4-402.3 (4) (b), AFTER RECEIVING RECOMMENDATIONS FROM THE HOSPITAL PROVIDER FEE OVERSIGHT AND ADVISORY BOARD ESTABLISHED PURSUANT TO SECTION 25.5-4-402.3 (6), FOR PREGNANT WOMEN, THE STATE BOARD BY RULE ADOPTED PURSUANT TO THE PROVISIONS OF SECTION 25.5-4-402.3 (5) (b) (III) MAY REDUCE THE PERCENTAGE OF THE FEDERAL POVERTY LEVEL TO BELOW TWO HUNDRED FIFTY PERCENT, BUT THE PERCENTAGE SHALL NOT BE REDUCED TO BELOW TWO HUNDRED TWENTY-FIVE PERCENT.

SECTION 10. 24-4-103 (8) (c) (I), Colorado Revised Statutes, is amended to read:

24-4-103. Rule-making - procedure - repeal. (8) (c) (I) Notwithstanding any other provision of law to the contrary and the provisions of section 24-4-107, all rules adopted or amended on or after January 1, 1993, and before November 1, 1993, shall expire at 11:59 p.m. on May 15 of the year following their adoption unless the general assembly by bill acts to postpone the expiration of a specific rule, and commencing with rules adopted or amended on or after November 1,
1993, all rules adopted or amended during any one-year period that begins each November 1 and continues through the following October 31 shall expire at 11:59 p.m. on the May 15 that follows such one-year period unless the general assembly by bill acts to postpone the expiration of a specific rule; EXCEPT THAT A RULE ADOPTED PURSUANT TO SECTION 25.5-4-402.3 (5) (b) (III), C.R.S., SHALL EXPIRE AT 11:59 P.M. ON THE MAY 15 FOLLOWING THE ADOPTION OF THE RULE UNLESS THE GENERAL ASSEMBLY ACTS BY BILL TO POSTPONE THE EXPIRATION OF A SPECIFIC RULE. The general assembly, in its discretion, may postpone such expiration, in which case, the provisions of section 24-4-108 or 24-34-104 shall apply, and the rules shall expire or be subject to review as provided in said sections. The postponement of the expiration of a rule shall not constitute legislative approval of the rule nor be admissible in any court as evidence of legislative intent. The postponement of the expiration date of a specific rule shall not prohibit any action by the general assembly pursuant to the provisions of paragraph (d) of this subsection (8) with respect to such rule.

SECTION 11. Effective date. This section and sections 1 and 12 of this act shall take effect upon passage; and sections 2 through 10 of this act shall take effect on July 1 of the year following the receipt by the revisor of statutes of the notice required by section 25.5-4-402.3 (7) (a), Colorado Revised Statutes.

SECTION 12. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.